EXHIBIT A

NEW YORK METHODIST HOSPITAL

100496723 CPTN 37 07/07/1969 F
BOOKER, SHERR-UNA
MARTIN, DEAN MR 4260066
PATIENT IDENTIFICATION

PERMISSION FOR OPERATION AND/OR PROCEDURE

1. I hereby authorize Dr. D'Ayala, his/her associates or assistants, and New York Methodist Hospital to perform an operation/procedure described as:

☐ Right ☐ Left ☐ N/A Digits: ☐ Hand _____ (name) ☐ Foot _____ (name)

Insertion of inferior vena cava filter
(Describe Operation / Procedure)

upon Sherr-una Booker
(Name of Patient)

2. Dr. _____ has fully explained to me the nature and purposes of the operation/ procedure and has also informed me of expected benefits and complications, attendant discomforts and risks that may arise, as well as possible alternatives to the proposed treatment, including no treatment. It has also been explained to me the possibility that I might require a blood/blood product transfusion. I further recognize that there are always risks to life and health associated with blood transfusions despite the fact that the blood has been tested. Such risks have been fully explained to me. I have been given an opportunity to ask questions, and all my questions have been answered fully and satisfactorily.**

3. I understand that during the course of the operation or procedure unforeseen conditions may arise which necessitate procedures different from those contemplated. I therefore consent to the performance of additional operations and procedures which the above-named physician or his/her associates or assistants may consider necessary.

4. For the purpose of advancing medical knowledge and education, I consent to the photographing, videotaping or televising of the operation or procedure to be performed, provided my/the patient's identity is not disclosed. I also consent to the admission of observers to the operating or treatment room of my case. I also consent to the publication and/or discussion provided my identity is not revealed.

5. Any organs or tissues surgically removed may be examined and retained by the Hospital for medical, scientific or educational purposes and such tissues or parts may be disposed of in accordance with custom and practice.

6. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the operation or procedure.

7. I confirm that I have read and fully understand the above and that all the blank spaces have been completed prior to my signing. I have crossed out any paragraphs above which do not pertain to me.

Witness:

(Signature)

OLUBUNMI BRIMMO, MD
(Print Name) (Title)

6-20-07 11:00 AM/PM
(Date) (Time)

Patient/Proxy/ Next of Kin / Guardian:*

(Signature)

Sherr-una Booker
(Print Name)

(Relationship, if signed by person other than patient)

6-20-07 11:00 AM/PM
(Date) (Time)

Interpreter (if necessary):

(Signature)

(Print Name)

AM/PM
(Date) (Time)

* The signature of the patient must be obtained unless the patient is under the age of 18 or incompetent.

PHYSICIANS ATTESTATION OF INFORMED CONSENT

I have explained the nature, purpose, benefits, risks of, and alternatives to, the proposed procedure/operation and have offered to answer any questions and have fully answered all such questions. I believe that the patient/proxy/next of kin/guardian fully understands what I have explained and answered.

Date: 6/21/07 Time: 7 AM/PM Physician: _____
(Signature)

** If the patient/proxy/next of kin/guardian refuses a blood transfusion, form #2839 "Refusal To Permit Blood Transfusion" must be completed according to the policy and such refusal must be attached to this form.

Day of Surgery / Procedure: Correct Patient / Procedure / Laterality Verification This section to be completed only if the consent is obtained prior to the day of surgery or procedure. *Note*: This is not used for the procedure "time out".

Date: _____ Time: _____ AM/PM

☐ Right ☐ Left ☐ N/A Digits: ☐ Hand _____ (name) ☐ Foot _____ (name)

Patient / Proxy / Next of Kin / Guardian: _____
(Signature)

If patient does not have capacity to sign and a surrogate is not available, patient / proxy signature is not required.

Member of Operative / Procedure Team: _____ MD / PA / RN / NP / DPM / DDS
(Signature)

ANESTHESIA CONSENT ON REVERSE SIDE - COMPLETE IF INDICATED

1629 (3/06)